IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 31, 2019

VCorp Agent Services, Inc., Registered Agent
Aperion Care Capitol, LLC
208 S. LaSalle Street
Chicago, Illinois 60604

RE: Complaint #: IL 107218, IL 107307
Survey Date: December 3, 2018
Docket #: 19-C0002
Violation Type: A Violation with Fine, 2-B Violations with Fines

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Aperion Care Capitol.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Aperion Care Capitol/December 3, 2018/19-C0002/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: APERION CARE CAPITOL COMPLAINT #: 0107218
LIC. ID #: 0054783
DATE COMPLAINT RECEIVED: 11/09/18 10:38:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
399	OTHER	2

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: APERION CARE CAPITOL COMPLAINT #: 0107307
LIC. ID #: 0054783
DATE COMPLAINT RECEIVED: 11/14/18 14:36:00

IDPH Code	Allegation Summary	Determination
118	RESIDENT RIGHTS	
199	OTHER	1

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

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RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. APERION CARE CAPITOL, LLC, D/B/A, APERION CARE CAPITOL Respondent.	)))))))))	Docket No. NH 19-C0002

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on December 3, 2018 at Aperion Care Capitol, 555 West Carpenter Road, Springfield, Illinois 62702. On January 30, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Aperion Care Capitol, 555 West Carpenter Road, Springfield, Illinois 62702 on November 5, 2018. The Facility's current license number is 0054783. The term of the conditional license shall be from February 28, 2019 to August 27, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON FEBRUARY 28, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

- **Type A violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1010h), 300.1210b), 300.1210d)2)3) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 31st day of January, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. APERION CARE CAPITOL, LLC, D/B/A, APERION CARE CAPITOL Respondent.	))))))))))	Docket No. NH 19-C0002

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Plan of Correction Required; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	VCorp Agent Services, Inc.
Licensee Info:	Aperion Care Capitol, LLC
Address:	208 S. LaSalle Street, Suite 814 Chicago, Illinois 60604

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 31st day of January, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. APERION CARE CAPITOL, LLC, D/B/A, APERION CARE CAPITOL, Respondent.	)))))))))	Docket No. NH19-C0002

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on December 3, 2018, at Aperion Care Capitol, 555 West Carpenter Road, Springfield, Illinois 62702. On January 30, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$4,400.00**, as follows:

- **Type B violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1010h), 300.1210b), 300.1210d)5) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)5) and 300.3240a).
  Fine = $2,200

- **Type B violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1010h), 300.1210b), 300.1210d)3) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b) and 300.3240a).
  Fine = $2,200

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 31st day of January ,2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. APERION CARE CAPITOL, LLC, D/B/A, APERION CARE CAPITOL , Respondent.	))))))))))	Docket No. NH 19-C0002

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Plan of Correction Required; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	VCorp Agent Services, Inc.
Licensee Info:	Aperion Care Capitol, LLC
Address:	208 S. LaSalle Street Chicago, Illinois 60604

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 31st day of January, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING: _____ B. WING _____	C 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 3 of 3 Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING: _____ B. WING _____	C 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S9999	Continued From page 1 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING: _____ B. WING _____	C 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S9999	Continued From page 2 made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to identify dangerously low blood glucose levels, failed to assess/monitor for adverse reactions following changes of insulin and fluctuating glucose levels, failed to assess and monitor risk factors of Urinary Sepsis and failed to provide coordination/continuity of care by medical professionals to maintain residents highest practical physical well-being for 2 of 11 residents (R4) reviewed for quality of care in the sample of 11. These failures resulted in R4 having an acute episode of hypoglycemia, which resulted in respiratory/cardiac arrest and subsequent death, and R2 being admitted to the hospital for Sepsis on 10/28/18 and 11/21/18. Findings include: 1. Electronic Health Record (EHR) Admission Note documents R4 as a 73 year old male admitted to the facility from another long term	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING: _____ B. WING _____	C 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 3	S9999		

care facility on 10/19/18 with diagnoses of Diabetes Mellitus Type 2 without complications, in part.

Admitting orders from the prior placement included: 1) (Finger stick blood glucose monitoring) Call MD (medical doctor) if blood sugar is less than 70 or greater than 450 before meals and at bedtime 2) Humalog (fast acting) U-100 Insulin Sliding scale with special instructions "Call MD if blood sugar is less than 70 or greater than 450" - (Blood Sugars in range of:) 70-149=0 units, 150-199= 3 units, 200-249=5 units, 250-299=7 units, 300-349=10 units, 350-400=15 units, >450 call MD before meals 7:00 AM-9:00 AM, 11:00 AM-1:00 PM, 4:00 PM-6:00 PM. Orders also included: 1) Humalog 10 units subcutaneous (subq) three times a day 8 AM, 12 noon and 5 PM, 2) Lantus (glargine) (long acting insulin) U-100, 18 units subq at hs (bedtime.) 3) Glucose chewable tablets 2 tabs daily PRN (as needed) - give if blood sugar is less than 70. R4's orders included diet orders for a LCS (low concentrated sweets/Regular diet and an HS (bedtime) snack "offer sandwich, yogurt, cottage cheese, etc. at (10 PM)."

The care plan, dated 11/7/18, identifies a focus area, "I have Diabetes Mellitus and am insulin dependent." with a goal to "have minimal complications related to diabetes through out the review date." Interventions include: Medication as ordered, monitor/document for side effects and effectiveness, fasting serum blood sugar as ordered by physician, monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of hyperglycemia; increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd (abdominal) pain, Kussmaul (deep labored)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING _____ B. WING _____	C 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

breathing, acetone breath (smells fruity), stupor, coma, Monitor/document/report PRN any s/sx of hypoglycemia; sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait and offer substitutes for food uneaten in part.

The Minimum Data Set (MDS) dated 10/26/18 documents R4 to be cognitively intact with a Brief Interview of Mental Status (BIMS) score of 14.

On 10/19/18, following admission, a new order for sliding scale (s/s) insulin was given by V24, R4's Attending Physician, which was as follows: 70-149=0 units, 150-199=3 units, 200-249=5 units, 250-299=7 units, 300-349=10 units, 350-400=12 units, 401-450=15 units, subq before meals. This was different for 350-400 and 401-450. There is no information as to why this would have been changed at the time and no documentation as to why the new order was obtained. A new order to increase the Lantus Solution 18 units to twice daily at 8 am and 8 PM was given in addition to the 10 units of Humalog at 8 am, 12 noon and 5 PM. This was an increase of the Lantus from 18 units once a day to 18 units twice a day.

V24, physician, documents his only visit to see R4 as a "Late Entry" dated 10/30/18 at 1:42 PM that reads "rounds were made with the presence of the nursing staff. Questions were answered to the presence of her patient. Medical Record was reviewed nurse's notes recommendations were made for updated on immunization recommending following the policy for the CDC (Centers for Disease Control) on opioid use and stewardship of antibiotics." The note finishes with "CKD (chronic kidney disease) Diabetes" but

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identifies no concerns with R4's blood sugars at the time.

The October 2018 Medication Administration Record (MAR), documents R4 receiving sliding scale insulin occasionally with the routine Humalog 10 units at 8 am, 12 noon, and 5 PM and 18 Units of Lantus at 8 am and 8 PM.

An Order Detail dated 11/5/18 at 9:22 PM documents the Glargine (Lantus) Solution 100 units/ml (milliliter) 45 units subcutaneously every day and 35 unit at bedtime was ordered by V23, Nurse Practitioner (NP). This was an increase of the Lantus from 18 units every AM to 45 units every AM and from 18 units at HS to 35 units at HS.

New orders received from V23, NP, on 11/5/18 at 9:16 PM with a start date of 11/6/18 documents a new sliding scale as follows for the Humalog 100 unit/ml (milliliter): 0-149 =3 units, 150-200 = 6 units, 201- 250 = 9 units, 251 - 300 units = 14 units, 301 - 350 = 18 units, 351 - 450 = 22 units, > (greater than) 450 call MD (medical doctor) for orders, subcutaneously with meals for DM (diabetes mellitus.) There was also an order for Metformin 500 mg twice daily at 8 am and 5 PM given by the NP on 11/5/18. Neither orders were signed until 11/12/18. There are no progress notes documented as to why V23 would order a new sliding scale and one that included 3 units for bloods sugars of 0-149 for which previously none would be given. There are no progress notes written by V23, NP, on 11/5/18 indicating that he had seen him.

The 2018 November MAR documents an order dated 11/5/18 for 45 units of Glargine (Lantus) Solution once daily given at 8 am on 11/6/18.

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R4's blood glucose was documented as 79 at 8 am. There are no progress notes or physician/nurse practitioner notes written at the time to explain why this 45 units was ordered on 11/5 and not given until 8 am on 11/6/18 when R4's Blood sugars were documented as 300 at 8 am with 10 units of Humalog given per sliding scale and a 450 at noon with 15 units documented as given per sliding scale. R4's blood sugar recorded at 5 PM on 11/5/18 is 241 with 5 units Humalog given and at HS, R4's blood sugar was recorded as 88. No additional insulin was given on 11/5/18 besides what was already ordered.

V23's note dated 11/5/18 documents "73 year old caucasian male resident seen today for a follow up to his type 2 diabetes and elevated blood glucose with c/o (complaints of) generalized pain and weakness." V23 documented the plan as "Discontinue all current diabetes regimen and start the new regime stated in progress notes. Get A1C (blood test that reflects average glucose levels over prior 6-8 weeks) in am and repeat in 3 mos (months)." There is no evidence that R4's attending physician was aware of these changes.

On 11/6/18 at 8 am, the MAR records R4's blood sugar as 79 with the 45 units of Glargine given in addition to 3 units according to the new sliding scale order received from V23, NP on 11/5/18. R4 was also recorded as receiving the Metformin 500 mg. R4's blood sugar at noon recorded on the MAR was 70 with 3 units of Humalog documented as given and at 5 PM, R4's blood sugars was recorded as 57 with 3 units of Humalog documented, but a "15" or "no insulin required" according to the MAR legend. R4's blood sugar recorded on the MAR for 8 PM on 11/6/18 is recorded as 230 on the "old" sliding

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S9999	Continued From page 7 scale with no sliding scale Humalog given. A Concern/Compliment Form dated 11/6/18 submitted by R4 to V4, Social Service Designee (SSD), documents R4 complained about having blood in his urine. Progress notes fail to document any follow up to this complaint. On 11/7/18 at 8 am, R4's blood sugar was documented as 81 with 3 unit of Humalog giving per sliding scale from NP along with 45 units of Glargine Solution and the Metformin. At 12 noon, R4's blood sugar was recorded as 297 with 9 units of Humalog given per sliding scale with a progress note written by V31, Registered Nurse (RN), which reflected the same sliding scale from V23 dated 11/5/18 with a statement at the end of "redundant order." At 5 PM, R4's blood sugar was 88 with 3 units given along with the Metformin. At 8 PM, R4's blood sugar was 230 with insulin documented as refused by R4 with no explanation. A Concern/Compliment Form submitted by R4 to V4, Social Service Designee (SSD), dated 11/7/18 documents R4 sometimes does not get his HS (bedtime snacks.) The form does not document any corrective action to R4's concerns and no follow up is evident. On 11/7/18, V23 documented another note (no time) which read "male resident seen today per nurse's request for a hypoglycemic episode and c/o lethargy." The plan was to "decrease Lantus (glargine) to 30 unit subq q (every) am and repeat A1C in 3 months." This was a decrease from 45 units. There is no indication that R4's attending physician was notified of the multiple changes made by V23, NP.	S9999		

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A physician order from V24, attending physician, dated 11/7/18 at 4:56 PM, documents a new sliding scale as follows: 0-149 = 0 units, 150-199 = 3 units, 200-249 = 5 units, 250-299 = 7 units, 300-349 = 10 units, 350 - 400 = 12 units, 401 - 450 = 15 units, subcutaneously before meals and at 9 PM, a new order from V24 for Glargine Solution 100 units/ml In ject 35 units subcutaneously at bedtime and inject 30 units subcutaneously one time a day for diabetes. The order was signed 11/9/18.

The MAR following the new orders from V24 reflects both sliding scale orders with the nurse documenting on both simultaneously. The MAR documents R4's blood sugar at 8 am on 11/8/18 as 233 with 9 units of Humalog given according to the sliding scale from V23, NP not V24, Physician's order of 11/7/18 which would have been for 5 units. At noon on 11/8/18, R4's blood sugar was recorded as 88 with 3 units given and at 5 PM, R4 was given 3 units of Humalog for a blood sugar of 116 according to the sliding scale from V23, NP not V24, physician, which would have been for none to be given. R4 received the Metformin 500 mg at 5 PM. R4 was given 35 units of Glargine (Lantus) at 8 PM with his blood sugar recorded as 267.

On 11/9/18, the MAR documents R4's blood sugar as 70 and was again given 3 units according to the sliding scale ordered by V23, NP, which should have been none given per V24's sliding scale. The MAR also documents R4 receiving 30 units of Glargine and the Metformin 500 mg. At noon, R4's blood sugar was recorded as 160 and was given 6 units according to V23's sliding scale, which should have been 3 units given per V24's sliding scale. At 5 PM, the MAR records R4's blood sugar as

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86 with 3 units of insulin recorded as given by V20, License practical Nurse (LPN), which should have been none given per V24's sliding scale. R4 received 35 units of Humalog at bedtime with a blood glucose of 80.

Progress notes entered between 11/5/18 and 11/10/18 when R4 was sent out reflects only one entry regarding R4's blood sugars and that was on 11/7/18 at 12:14 PM entered by V31, Registered Nurse (RN.) The entry documents the sliding scale ordered by V23, NP, and ends with the statement "Redundant order." There is no evidence the facility nurses were monitoring R4's response to the change in insulin orders, his fluctuating and repeated low glucose level and his food intake in an effort to determine the cause of the fluctuations.

On 11/28/18 at 12:30 PM, V2, Director of Nurses (DON), was asked to provide V24's standing orders and stating she'd try to find some. At 1:00 PM, V2 provided a copy of the standing orders that had just been faxed from V25's office at 12:43 PM on 11/28/18. The standing orders document, "When patient's blood sugar is < (less than) 80 and patient has symptoms, patient should be treated with a dose of Glucagon followed by a meal that is substantial and the blood sugar should be checked every 15 minutes x 2 and then every hour until stable oral hypoglycemic events should be reported immediately and the root cause corrected." There is no evidence the facility nurses had V24's standing orders or that they follow his orders for a low blood sugar.

On 11/8/18, notes documented by V23 NP indicate R4 had swelling and tenderness to the index finger of his left hand. A note dated

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11/9/18 written by V23 documents he ordered Keflex 750 mg (milligrams) twice daily times 7 days for an infection.

Meal Intake records for R4's stay from 10/19/18 through 11/9/18 documents he ate 75-100% of most meals except supper on 11/8/18 when he was documented as eating 50-75%. The facility was unable to provide intake records for HS snacks as evidence of monitoring his intake.

EHR progress notes dated 11/10/18 at 9:22 am entered by V30 LPN documents under narrative "Resident v/s (vital signs) 60/40, 45, 96.1, 12 blood sugar read low resident unresponsive glucagon shot given. Resident still unresponsive 911 called another glucagon shot given blood sugar up to 51 resident not responding EMT's (emergency medical technician) here working on resident. EMT stated resident is coding CPR (cardiopulmonary resuscitation) initiated by EMT. Resident left facility with EMT's continuing CPR going to ER (Emergency Department). (V23) NP aware and (V2) DON (Director of Nurses) Resident own POA (power of attorney) and no other contacts available.

Hospital Emergency Department notes documents R4 presented in full respiratory and cardiac arrest on arrival. History and Physical notes dated 11/10/18 at 11:16 AM documents under impression "Acute hypoxic/hypercapneic respiratory failure 2/2 (secondary) severe hypoglycemia requiring mechanical ventilation and Asystolic s/p (status post) asystolic cardiac arrest" and Severe Sepsis 2/2 Urinary tract infection. R4 expired following family consent to remove ventilator.

On 11/29/18 at 8:50 am, V30, LPN, stated the

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incident occurred before 7 am on 11/10/18 when she went in to do treatments on R4's feet. V30 stated she noticed that he wasn't himself, unresponsive.

On 11/16/18 at 1:35 PM, V23, Nurse Practitioner, stated he had seen R4 several times and wrote notes on him on his computer and stated he didn't know the dates off hand and hadn't given the notes to the facility yet. He recalled R4 as being tall, thin and fragile. V23 stated he knew R4's blood sugars were running high, running low, and didn't know if he snacked a lot or if his family brought food in for him. V23 stated "one minute it would be 500-600 then bottom out." When asked what he meant by "bottoming out," V23 stated a blood sugar of 50-60. V23 was asked if he was aware that R4 already had sliding scale insulin ordered when he ordered one on 11/6/18 and stated "yes," but couldn't state why he reordered one. V23 stated the facility nurse had texted him at the time. V23 was asked if he specifically ordered the blood sugar of 0-149 = 3 units on the sliding scale dated 11/6/18, stated yes and when asked why, could not say. V23 repeatedly stated he needed to check his notes in his computers. Asked why the facility didn't have access to his notes, V23 stated they are just in the processes of setting him up to the printer so he can print out his notes when he does them. V23 stated he "would not typically order 1-149 =3 units" so he was thinking an error occurred, but stated even if he did, the nurses should have held the insulin if his blood sugars were under 80-90. The orders dated 11/5/18 for the sliding scale were signed by V23 on 11/12/18, after R4 had expired. V23 stated it would be the nurses discretion to give or not to give the insulin with a low sugar, but he would expect them to hold it, stating they should have known better. V23 stated

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he was not notified about the low blood sugars R4 was consistently having after 11/7/18 even though he had seen him on 11/8 and 11/9/18. V23 agreed that infections can cause a fluctuation in blood glucose levels.

On 11/28/18 at 10:30 am, V31, RN, recalled R4 well describing him as alert and oriented times three. V31 stated she remembered R4 as having really low blood sugars that V23, NP, changed his insulin drastically for. V31 was asked about a progress note dated 11/7/18 at 12:14 PM where a new sliding scale which started out with 0-149 = 3 units was ordered by V23 and V31 stated V23 was in the building when she printed out the blood sugars for him. V31 stated V23 reviewed them before giving her the new orders for the sliding scale. V31 stated V23 actually gave her the numbers for the sliding scale which included the 0-149 = 3 units. V31 was asked why she documented "redundant" when the new sliding scale was different from the old, stated because R4 already had an order for sliding scale insulin. V31 was asked why she would document on both sliding scales simultaneously and stated she didn't know why the "system would allow two to be printed out anyway." V31 stated R4 always wanted to know what his blood sugar was and how much insulin he was getting as he was very aware of what he needed. When asked if she ever held R4's insulin due to his blood sugar being too low, stating "I never considered holding his insulin" and if I had, I would have documented it as being held. V31 was asked about R4's eating habits and stated he had a lot of snacks in his room and sometimes he ate, and sometimes he did not. V31 stated he also had cellulitis of his finger at the end which could have also caused his blood sugars to fluctuate. V31 stated she did not document any assessment towards R4's

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adjustment to the insulin at the time as she didn't see any difference. V31 stated she was here the morning he "crashed" and stated she heard V30, LPN, yelling for her to come down. V31 stated she ran down to get the Glucagon injection then ran down to get the printed information to send with him to the ER (Emergency Room). V31 stated V30 gave the injection and 911 was called. V31 stated she understood that he didn't "crash" until the paramedics got here.

On 11/28/18 at 11:40 am, V24, R4's attending Physician/Medical Director, stated he didn't immediately recall R4, but that he was unaware that V23, NP, gave multiple insulin orders for R4 in the week following his hospitalization. V24 explained that V23 works for a different company than his so he is not privy to any information from V23 unless the facility informs him or provides it which they did not. V24 stated the facility nurses call V23 often and V23 is there every day, but they don't always let V24 know what's going on. V24 stated he recently had a major meeting with the facility over this problem as he sent his nurse down to the facility and she was denied access to the medical records of V24's patients. V24 stated he also makes rounds with a nurse at the facility who isn't actually the nurse taking care of the residents and she doesn't know if there are any changes that have occurred or if there is anything going on with the resident at that time. V24 stated he would expect to be called with any condition change including any time there is a hypoglycemic episode that's symptomatic. V24 stated he doesn't like sliding scale insulin as it tends to over correct a resident causing more problems. V24 stated he likes to keep the am blood sugar 140 or below and would expect them to recheck a blood sugar 2 hours after they eat and let me know the results. V24 stated he has

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standing orders for everything including diabetes, but "facility nurses do not follow them." When asked about the sliding scale from V23 with the 0-149 = 3 units, V24 repeated he was unaware of that and would have expected his standing orders to be followed. V24 stated he would also expect them to monitor the resident after insulin changes for adverse reactions. V24 was asked about when to contact him, stating he would expect them to contact him whenever a resident has a hypoglycemic episode and during a significant condition change. V24 stated he does not want them contacting V23 instead. When asked about the nurses giving insulin with low blood sugars, V24 stated the nurses don't follow standards of practice. V24 stated they have agency nurses sometimes who aren't familiar with the residents at all stating "continuity of care is a problem."

On 11/15/18 at 10:45 am, V43, R4's family member, stated R4 told family members that he was getting too much insulin and that he had diabetes for over 20 years and was well aware of what he needed. V43 stated that she was told by R4 that he'd refused it a couple of times, but that the nurses did not really assess the insulin situation well.

The facility's policy entitled "Hyperglycemia" (undated) but faxed 11/29/18 documents "Resident will be monitored for s&s (signs and symptoms) of Diabetic coma (also known as hyperglycemia condition that occurs in diabetic residents when they do not receive enough insulin to metabolize carbohydrates, when there is increased stress, or infection. The onset is gradual. Under Procedure, the policy documents "Should you observe a diabetic resident, or should a diabetic resident complainn of any of the following symptoms an accu-check will (should

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S9999	Continued From page 15 any symptoms exist, the accu-check would reveal a high blood sugar > (greater than) 300.) Report all changes in the diabetic resident to the physician IMMEDIATELY." The symptoms include: "breathing difficulties and increased respirations, sweet or fruity breath, flushed skin, loss of appetite, nausea and/or vomiting, increased thirst and dry tongue, dry skin, increased urination, senses are dulled, complaints of aches, loss of consciousness." The facility's policy/procedure entitled "Hypoglycemia" (undated) but faxed 11/29/18 documents "It is appropriate at the time of admission to request an order for finger stick blood sugars. Diabetic residents who exhibit signs/symptoms of Hypoglycemia/Insulin reactions to determine the blood sugar level. "Fingerstick" blood sugar monitoring may be performed when a change in status is observed and hypo or hyper glycemia is suspected. The signs/symptoms of hypoglycemia includes: generalized muscular weakness, sweating, nervous instability, trembling, faintness, hunger pangs in epigastrium, headaches, numbness or tingling of tongue or lips, rapid heart action, confusion, double vision, and unsteady gait. The policy continues to document "Give some form of glucose if resident is conscious. A) Mild reaction - small amount of food - 10-15 gm carbohydrates (such as orange juice, 6 oz of regular soda, 8 oz of 2% skim milk) repeat in 10-15 minutes as needed. B) Moderate reaction - (drowsy, profuse perspiration, blood glucose 3-50 below normal)... The policy documents "contact Physician if blood sugar is below 60 unless there are specific call parameters." The policy also documents "Document findings, interventions, and MD contact in resident's clinical record."	S9999		

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2. On 11/15/18 at 11:01 AM, R2 stated she is incontinent and does need assistance with incontinent care and has a history of Urinary Tract Infections (UTI). R2 further stated she woke up in the hospital back in October, 2018 and when she woke up "incoherent and next thing I know I'm in ICU." R2 felt the facility failed to identify her UTI, which subsequently lead to her having Sepsis. R2 stated she is not sure that her Primary Care Physician (V24) is notified of her condition changes, and that only Nurse Practitioner (NP), V23 is notified.

R2's MDS, dated 10/2/18, documents R2 having a BIMS score of 15, indicating intact cognition and occasionally incontinent of urine.

R2's Care Plan dated 6/29/18 and revised on 10/3/18 documents, R2 being "rejective of cares," and having an Activities of Daily Living (ADL) self-care performance deficit, having limited physical mobility, being at risk for fall/injury from weakness and tiredness. The Care Plan does not list what ADL self-care performance deficit R2 has, nor does the Care Plan reflect which areas of care R2 is resistive to.

Nurse's Notes dated 10/28/18 at 9:50 AM documents, R2 reported feeling nauseous this am and when asked by V46, LPN, when her symptoms began, R2 stated "late last night." The Nurses Note further documents R2 had no emesis at the time and V23, NP, was notified. There is no documentation that R2's primary physician was notified.

Nurse's Notes dated 10/28/18 at 10:57 AM, documents in part, "Writer went into resident's room (R2) to give medicine at this time because

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she was unable to take medicine earlier and had fallen back to sleep. Writer had assessed temp this am it read at 98.8. Temperature was 100.6 upon reassessing. Skin warm to the touch. Left leg is slightly more red than the right one. No emesis but still feeling nauseated. (V23, Nurse Practitioner) notified. Orders to send to Er (sic) for evaluation requested." The Nurse's Note do not reflect R2's physician was notified.

Hospital History and Physical dated 10/28/18 documents R2 having "Severe Septic Shock," and having UTI and lower extremity cellulitis.

Hospital Summary dated 10/31/2018, documents R2 having "Sepsis secondary to E. Coli (Escherichia coli) in urine."

Hospital History and Physical dated 11/21/18 documents R2 being admitted for "septic shock secondary to UTI."

On 11/29/18 at 1:20 PM, V2, Director of Nursing (DON), stated it is the expectation for nursing assessment to be done anytime there is a change of condition.

Facility Policy entitled Assessment of Resident, dated 11/28/12 and revised on 1/29/18, documents in part, "To gather comprehensive information as a basis for identifying resident problems/needs." The policy further documents in part, "8. If reassessing resident, review previous nursing progress notes, physician's orders and progress notes, laboratory test results, residents response to current treatments. 10. Notify the attending physician of significant findings and request necessary change in orders." The Policy also identifies assessments are to be performed when the resident's past or

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S9999	Continued From page 18 current history indicates the need/problem is present, and/or as observed or deemed necessary. (A) 300.610a) 300.1010h) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant	S9999		

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S9999	Continued From page 19 change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having	S9999		

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S9999	Continued From page 20 pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on interview, observation, and record review, the facility failed to promptly identify, assess, treat and monitor pressure ulcers to prevent deterioration and failed to ensure timely repositioning for 2 of 4 residents (R3, R4) reviewed for pressure ulcers in a sample of 11. This failure resulted in deterioration of R4's pressure ulcers per physician's assessment. Findings include: 1. The Admission Record documented R4 as a 73 year old male admitted to the facility on 10/19/18 with diagnosis of Diabetes Mellitus II in part. R4's Physician/Discharge Orders, dated 10/19/18 from discharging facility , documented "Cleanse stage 2 pressure injury to right heel and stage 3	S9999		

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pressure injury to left heel with wound cleanser and pat dry. Apply Allevyn dressing every other day."

The Minimum Data Set, MDS, dated 10/26/18, documented R4 to be cognitively intact with a Brief Interview of Mental Status (BIMS) score of 14. The MDS documents R4 requires extensive assist of one staff for bed/transfers.

The Care Plan dated 10/21/18 documents R4 to have pressure ulcers to his left/right heels. The goal was for the ulcers to show signs of healing and remain free of infection. Interventions include in part: Administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing, measure length, width, and dept where possible, Report improvements/deterioration to MD (medical doctor), monitor dressing to ensure it is intact and adhering, report loose dressings to nurse, and "weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.

The Treatment Administration Orders (TAR) for October 2018 documents the right heel stage II pressure ulcer treatment was initialed as done on 10/20, 10/22, 10/28 and 10/30/18 and was ordered to be done every other day but reflects no treatments done for the left heel.

The weekly skin observations dated 10/22/18 identifies R4's right/left heel ulcers but includes no measurements. This form identified the ulcers as being present on admission.

A "Concern/Compliment" submitted by R4 dated 11/6/18 documents "that his dressing on his R (Right arm) and heels haven't been changed as

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S9999	Continued From page 22 scheduled". On 11/15/18 at 3:00 PM, V3, Licensed Practical Nurse, LPN provided the first wound assessment for R4's feet and is dated 10/26/18, 7 days after admission. The Wound Assessment provided by V3 dated 10/26/18 documents R4's left heel pressure ulcer as having "slough/eschar" measuring 0.7 cm (centimeter) x (by) 1.2 x 0.8." The right heel was documented as same with measurements documented as 1.4cm x 1.6cm x 1.1cm. The first entry into the Electronic Health Record (EHR) is on 10/29/17 at 8:01PM entered by V20 Licensed Practical Nurse (LPN) documents "WEEKLY SKIN OBSERVATIONS GENERAL SKIN OBSERVATIONS: Weekly skin observation completed for (R4) Skin is warm, dry, within normal limits. Skin turgor is fair. SKIN CONCERNS: Skin intact, no concerns noted. FOOT OBSERVATIONS/CARE: No foot concerns noted." The Electronic Progress Record (EHR) dated 10/30/18 documents R4 was seen be the Wound Specialist, V21. V21's "Initial Wound Evaluation & Management Summary" dated 10/30/18 documents R4 to have an "unstageable (due to necrosis) of the left heel" measuring 0.6cm x 0.5 x not measurable" with 50% necrotic tissue and 50% granulation. The report documents R4's right heel measures "1.3cm x 1 x not measurable" with 100% necrosis. The order for these wounds was "Alginaid calcium apply once daily." The October 2018 TAR/MAR (Medication Administration Record) failed to document V21's	S9999		

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orders given on 10/30/18. The October (MAR) documents R4's Left heel treatment ordered every other day was only documented as done on 10/20, 10/22, 10/26, 10/28 and 10/30/18 missing the treatment on 10/24/18. R4's right heel treatment documented on the TAR also ordered every other day was documented as done only on 10/20, 10/22, 10/25, 10/28 and 10/30/18 with none being documented as done on 10/24 and 10/26/18.

A Weekly Skin Observation, dated 11/5/18, completed by V25, LPN, documents R4 to have no foot concerns with skin intact even though R4 has unstageable ulcers on both heels.

V21's, Wound Specialist, "Wound Evaluation & Management Summary" dated 11/6/18 documents decline in the left heel with measurements as "1.5cm x 1.5cm x not measurable" with 100% necrosis. R4's left heel pressure ulcer also documented decline with measurements as 1.5cm x 1.7cm x not measureable" with 50% necrosis and 50% granulation. V21 documented for both left heel and right heel that the deterioration was due to edema and "ordered dressing not in place."

The November 2018 TAR or MAR fails to include any treatment orders for either of R4's heels therefore none are documented as done.

2. R3's Admission Record, undated, documented she had diagnoses of Pressure Ulcer to Left Heel, Osteomyelitis and Diabetes Mellitus without Complications.

R3's MDS's, dated 10/23/18 and 10/31/18, document R3 required extensive assistance from

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staff for bed mobility, toilet use and personal hygiene. R3's MDS documented she required total assistance from staff with transfers.

R3's Skin Assessment, dated 11/13/18, documents R3 scoring a 16 on the Braden Observation Assessment, indicating being at risk for skin breakdown.

Physician Wound Evaluation authored by V21, Wound Specialist, dated 11/13/18, documents R3 had a pressure ulcer to her buttock which was "Resolved".

On 11/16/18 8:15 AM R3 was lying in bed on her left side with 2 pillows underneath her head and 2 incontinent pads underneath her buttocks. R3 had an opened pressure ulcer on her right buttock that was beefy red in color. There was no dressing on R3's pressure ulcer. V11, Certified Nursing Assistant (CNA), stated, "I just creamed it (buttocks)," and further stated she hadn't informed the nurse of the open area to R3's right buttock.

On 11/16/18 at 11:10 AM, R3 was up in the chair at bedside. R3 stated her "butt" was hurting. At 12:14 PM, R3 remained up in her chair in the therapy room. At 1:15 PM, R3 remained up in the wheelchair in her room, and stated she had "been up since this morning."

R3's TAR dated 11/1/18 through 11/30/18 did not list a treatment for R3's the open area to her right buttock. The November 2018 TAR or MAR fails to include any treatment orders for R3's right buttock.

R3's Care Plan dated 8/30/2018 and revised on 10/17/2018 did not document anything regarding

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a pressure ulcer to R3's right buttock. R3's Care Plan further documents R3 having potential for impairment to skin integrity related to fragile skin, impaired mobility, incontinence, having a diagnosis of Diabetes Mellitus and having had amputated toes to her right foot.

On 12/3/18 at 8:30 AM, V2, DON, stated she had just went and assessed R3's buttock and found it to be "closed now." V2 further stated she cannot determine when the wound was closed, could not verify the measurements at the time of initial findings of R3's open wound, and that there was not a treatment for R3's buttock on 11/16/18 at the time it was identified. V2 further stated she would have expected the CNA to report any skin changes to the nurse and for the nurse to notify the physician and seek treatment orders, and to have the Care Plan updated with the pressure ulcer included to R3's right buttock.

On 11/28/18 at 11:40 AM, V24, R3's attending Physician/Medical Director stated in part, the facility nurses call V23, Nurse Practitioner (NP) and he is there every day but they don't always let him know what's going on. He stated he recently had a major meeting with the facility over this problem as he sent his nurse down to the facility and she was denied access to medical records. V24 said the other problem is that he makes rounds with a nurse who isn't actually the nurse taking care of the residents and she doesn't know if there has been any changes or what's going on with the resident at that time. V24 states he would expect to be called with any condition changes. V24 further stated he has standing orders for everything, which they do not follow. V24 asked about when he expected the nurses to contact him, stated he would expect them to contact him whenever a resident has a significant

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condition change. V24 stated he does not want them contacting V23 instead. V24 stated there is no continuity of care.

The facility's policy/procedure entitled "Pressure Injury and Skin Condition Assessment" dated 1/17/18 identifies the purpose as: "To establish guidelines, monitoring and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implementing" and "Pressure and other ulcers will be assessed and measured at least every seven (7) days by licensed nurse, and documented in the resident's clinical record." The policy documents "A skin condition assessment and pressure ulcer risk assessment will be completed at the time of admission/readmission" and "a wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse. The policy documents wound assessment will include site location, size, stage, odor, drainage, description and date/initial of individual performing the assessment. The policy documents "a license nurse shall observe condition of wound incision daily or with dressing changes as ordered" with notation documented in the nurse's notes.

Facility Policy dated 11/28/12, and revised on 11/17/18, entitled Pressure Injury and Skin Condition Assessment, documents in part, "Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented." The Policy documented "3. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse." The Policy continued to

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S9999	Continued From page 27 document "6. Care givers are responsible for promptly notifying the charge nurse of skin breakdown." It continued "16. The licensed nurse is responsible for notifying the attending physician, Director of Nursing and legal representative. 17. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care. 18. Physician ordered treatments shall be initiated by the staff." (B) 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.	S9999		

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S9999	Continued From page 28 Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999		

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3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to monitor and assess signs and symptoms of Urinary Tract Infections (UTI), perform complete incontinent care, indwelling urinary catheter care and urostomy care and timely toileting for 5 or 5 residents (R1, R4, R5, R6, and R7), reviewed for in a sample of 11. This failure resulted in R4 being sent to hospital with partial diagnosis of Severe Sepsis related to UTI.

Findings include:

1. R4's Minimum Data Set, MDS, dated 10/26/18 documents R4 to be cognitively intact with a

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BIMS score of 14. The MDS documents R4 to have a catheter on admission and be frequently incontinent of bowel. The MDS also documents R4 requires extensive assist of one staff for transfers.

Physician's orders document "16 fr (french) 10cc (cubic centimeters) foley cath, Change monthly on the 24th every night shift starting on the 24th and ending on the 24th every month for urinary retention -Start Date- 10/24/2018 2200"

R4's Care Plan dated 10/26/18 documented R4 to have a Focus area "Catheter r/t (related to) Urinary retention and BPH (benign prostatic Hyperplasia)." The goals documented " I will show no signs or symptoms of Urinary infection through review date" with interventions as follows: "Check tubing for kinks each shift, Monitor and document intake and output as per facility policy, Monitor for s/sx (signs/symptoms) of discomfort on urination and frequency, Monitor/document for pain/discomfort due to catheter, Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns and Position catheter bag and tubing below the level of the bladder and away from entrance room door."

The October 2018 Treatment Administration Record (TAR) documents R4's catheter on 10/24/18.

A "Concern/Compliment Form" dated 11/6/18 documents R4 submitted concerns to the facility stating "He has been telling the nurse for the last

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couple of days that his catheter has blood and nurse stated it is due to be changed on the 24th."

On 11/7/18, A "Concern/Compliment Form" submitted by R4 documents "He stated sometimes sat on toilet over weekend for an hour + (and) half s (without) anyone coming."

Neither Form has any summary to pertinent findings on these voiced concerns and neither has any corrective actions documented as being taken.

On 11/29/18 at 1:30pm, V4 Social Service Designee (SSD) stated she gave a copy of R4's concerns to nursing and didn't know how they resolved the blood in the catheter. V4 stated they did check on the sitting on the toilet for a long time complaint and couldn't tell by the video's if staff left him or not.

On 11/29/19 at 1:40 PM, V2 Director of Nurses (DON) stated she was unaware of R4's complaints of blood in his catheter therefore has no documentation to show the facility followed up on this complaint.

The Electronic Health Record (EHR) progress notes from R4's admission to his discharge to the hospital on 11/10/18 fail to document any concerns and/or information at all on R4's catheter and/or the status of his urine.

Hospital Emergency Department notes documents R4 presented in full respiratory and cardiac arrest on arrival. History and Physical notes dated 11/10/18 at 11:16 documents under impression "Acute hypoxic/hypercapneic respiratory failure 2/2 (secondary) severe hypoglycemia requiring mechanical ventilation

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S9999	Continued From page 32 and Asystolic s/p (status post) aystolic cardiac arrest" and Severe Sepsis 2/2 Urinary tract infection." R4 expired following family consent to remove ventilator. There is no evidence any nurses followed up to R4's complaints about blood in his catheter on 11/6/17 or the days prior. Facility Policy entitled Incontinence Care, dated 11/28/12 and revised on 1/16/18, documents in part, "Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or every two hours." Facility Policy entitled UROSTOMY CARE, dated 11/29/2018, documents in part, "A. POLICY Urostomy care will be given by RN (Registered Nurse) or LPN (Licensed Practical Nurse), to prevent excoriation and infection." Facility Policy entitled Urinary Catheter Care, dated 11/28/12 and revised on 1/17/17, documents in part, "Urinary Catheter Care. 12. Catheter drainage bags shall be emptied one time on each shift or as needed, using a separate collecting container for each resident's drainage bag." 2. On 11/15/18 at 9:52AM, R1 sat in her wheelchair in the library room on 2nd floor with her upper torso leaning forward onto her lap. A strong urine odor was noted. V11 and V14, Certified Nursing Assistants (C.N.A.), stated they were going to take R1 back to her room to perform hygiene. V14 removed R1's incontinent brief which was saturated with urine, and R1 having a large brown ring around the perimeter of	S9999		

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her white pants beginning at the top of her bilateral hips, extending down to her bilateral mid thighs. R1's pants were urine soaked. Also present on R1was bilateral deep creases to R1 buttocks extending down to her bilateral thighs. Surveyor asked V11 if the incontinent brief was urine soaked. V11, CNA, replied: "Yes, I would say!" As V11, CNA, performed incontinence care on R1, but failed to perform incontinence care to R1's entire right side of her body.

R1's Care Plan dated 7/27/18, document R1 requiring extensive assistance with toileting, and has impaired cognitive thought processes related to dementia.

R1's Minimum Data Set (MDS) dated 9/25/18 documents R1 being incontinent of bowel and bladder and having functional limitations to her lower bilateral extremities and requires extensive assistance for toileting and hygiene. R1's MDS further documents R1 having severely impaired cognition.

Hospital Emergency Department (ED) progress notes dated 11/23/18, documents R1 being admitted for UTI (urinary tract infection), GI (Gastrointestinal) Bleed, and Pneumonitis.

3. R5's MDS dated 10/5/2018, documents R5 had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition intact. The MDS also documented R5's required total dependence on staff for personal hygiene and toileting. The MDs documents R5 was incontinent of bowel. R5's MDS further documents R5 having the following diagnoses: Quadriplegia and a seizure disorder.

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R5's Physician's Order dated 10/19/2018 documents R5 is to be provided ostomy care and verify patency for her urostomy.

R5's Medication Administration Record (MAR) dated 10/1/2018 through 10/31/2018, documents in part, "Provide Ostomy care and verify patency every shift for urostomy." The MAR further documents R5 not having received ostomy care on the evening shift on 10/30/18.

R5's MAR dated 11/1/2018 through 11/30/2018, documents R5 did not receive ostomy care on 11/2/18 on the day shift.

R5's Care Plan revised on 10/22/2018 documents in part R5 having the Methicillin Susceptible Staphylococcus Aureus (MRSA) infection and having alteration in urinary elimination related to her Urostomy. The Care Plan also documents intervention to empty urine drainage bag every shift and to monitor for signs and symptoms of Urinary Tract Infection (UTI), changes in color or clarity of urine. The Care Plan further documents R5 having an Activities of Daily Living (ADL) self-care performance deficit.

On 11/15/18 at 4:10PM, R5 stated in part, she cannot change her urostomy independently. R5 further stated "It (urostomy) a lot of times it doesn't get changed."

4. R6's MDS dated 11/07/18 documented R6 had a BIMS score of 12, indicating moderately impaired cognition. The MDS also documented R6 required extensive assistance with personal hygiene and toileting, and being frequently incontinent of bowel. The MDS further

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S9999	Continued From page 35 documented R6 having a history of Multidrug-Resistant Organism (MDRO), Diabetes Mellitus (DM), Retention of Urine, and Portal Hypertension. R6's Care Plan initiated on 7/27/2018 and revised on 9/20/18, with a resolved date of 9/20/2018, documents in and requiring extensive assistance with toileting. R6's Care Plan also documents R6 having in part, the following diagnoses: Urinary Tract Infection. The Care Plan further documents in part, " (R6) have an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) (Indwelling Urinary) Catheter Use, Muscle Wasting and Atrophy and Neuropathy." R6's Care Plan with initiation date of 8/1/18 documented he had an indwelling urinary catheter related to urinary retention. This care plan did not document when and how often R6 should be receiving catheter care. R6's Care Plan with initiation date of 9/26/18 stated that he had Urinary Tract infection with Vancomyacin Resistant Enterococci (VRE). The Interventions listed were "Monitor use of catheter and not characteristics of urine." On 11/15/18 at 4:03 PM R6 was lying on his back with his left leg hanging off the side of his bed. As V26, Certified Nursing Assistant (CNA), removed R6's blanket, R6's leg collection urine bag appeared to be wet on the outside of the bag, which was full of dark amber urine. V26, CNA, noted 1000 milliliters (ml)/cubic centimeters (cc) of dark amber urine in the bag when she measured R6's urine output. V26 stated "(R6) is supposed to have a catheter bag not a leg bag when in bed."	S9999		

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On 11/15/18 at 4:12PM, R6 stated "(Staff) don't do catheter care every day, let alone on multiple times a day. I'm lucky if they do it every 2 days. They never empty the bag (urine) like they should either."

Progress Notes dated 11/15/2018 through 11/26/18 16 reflects the following diagnoses for R6: Urinary Tract Infection (UTI), site not specified and Congestive Heart Failure (CHF).

R6's MAR, dated 10/1/2018 through 10/31/2018, documents in part, "(Indwelling urinary) cath (catheter) care q (every) shift." The MAR further documents R6 not receiving (indwelling urinary) catheter care on the following dates and shifts: 10/3/18 (days), 10/6/18 (evenings), 10/7/18 (evenings), 10/19/18 (nights), 10/23/18 (days), 10/24/18 (days), 10/26/18 (days), 10/27/18 (days), and 10/31/18 (nights).

R6's MAR dated 11/1/2018 through 11/30/2018, documents R6 failed to receive (indwelling urinary) catheter care on 11/17/18 on the evening shift.

Nurse's Notes dated 11/20/2018 at 1:00AM, documents in part, "POA (Power of Attorney) Update on residents (R6) condition given. POA requesting UA (urinalysis) C&S (culture and sensitivity). Also stated she did not want resident sent to hospital at this time."

Nurse's Notes dated 11/20/18 at 4:00AM, documents in part, "Resident (R6) being sent to (hospital) d/t (due to) critical potassium of 6.1 and critical platelet of 12."

Hospital Report dated 11/20/18 documents in part, R6 being sent to the Emergency Department

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(ED) for an evaluation. The Emergency Medical Services (EMS) brought R6 to the ED from the facility for evaluation of sepsis criteria. The Report also documents in part, "Septic Shock present: YES - Lactic Acid >=(greater than/equal to)4. Sepsis Diagnosis: Septic Shock - Severe Sepsis." The Hospital Report further documents (R6) has a history of UTI with an indwelling (indwelling urinary) catheter, and a history of Vancomycin-Resistant Enterococci (VRE) organism in his urine.

On 11/26/18 at 1:55PM, V3, Assistant Director of Nursing (ADON), stated "There should not have been a leg bag on him when he (R6) was put to bed. Also, there should never be 1000 cc of urine in any bag when it is emptied. It should have been emptied long before that."

5. R7's MDS dated 10/11/18, documents R7 is cognitively intact with a BIMS score of 15. The MDS documented R7 required extensive assistance for personal hygiene and toileting. R7's MDS further documents R7 having in part the following diagnoses: Disorder of Kidney and Ureter and an Overactive Bladder.

Physician's Order dated 10/2/18 documents R7 having a Catheter and requiring the catheter to be flushed with sterile water every 8 hours as needed, related to R7's Neuromuscular Dysfunction of the Bladder.

R7's MAR dated 10/1/2018 through 10/31/2018, documents R7 having Malignant Neoplasm of Kidney, requiring catheter care every shift related to Neuromuscular Dysfunction of the Bladder, receiving Levsin Tablet 0.25 milligrams (mg) as needed for bladder spasms, and receiving Oxybutynin Chloride Tablet 5 mg three times daily

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S9999	Continued From page 38 for his overactive bladder. R7's Care Plan initiated on 10/3/18 documents R7 having a catheter. The Care Plan does not list any interventions for R7 to receive catheter care. On 11/15/18 at 4:20PM, R7 stated in part when asked about catheter care, "No, no, not do the cleaning for me, the staff just get me the supplies; I don't get catheter care at all." R7 further stated he empties his own urine out of his catheter bag. On 11/29/18 at 1:20PM V2, Director of Nursing (DON) stated she would expect staff to perform complete incontinent care, (indwelling urinary) catheter care, and urostomy care as ordered as well as on an as needed basis. (B)	S9999		